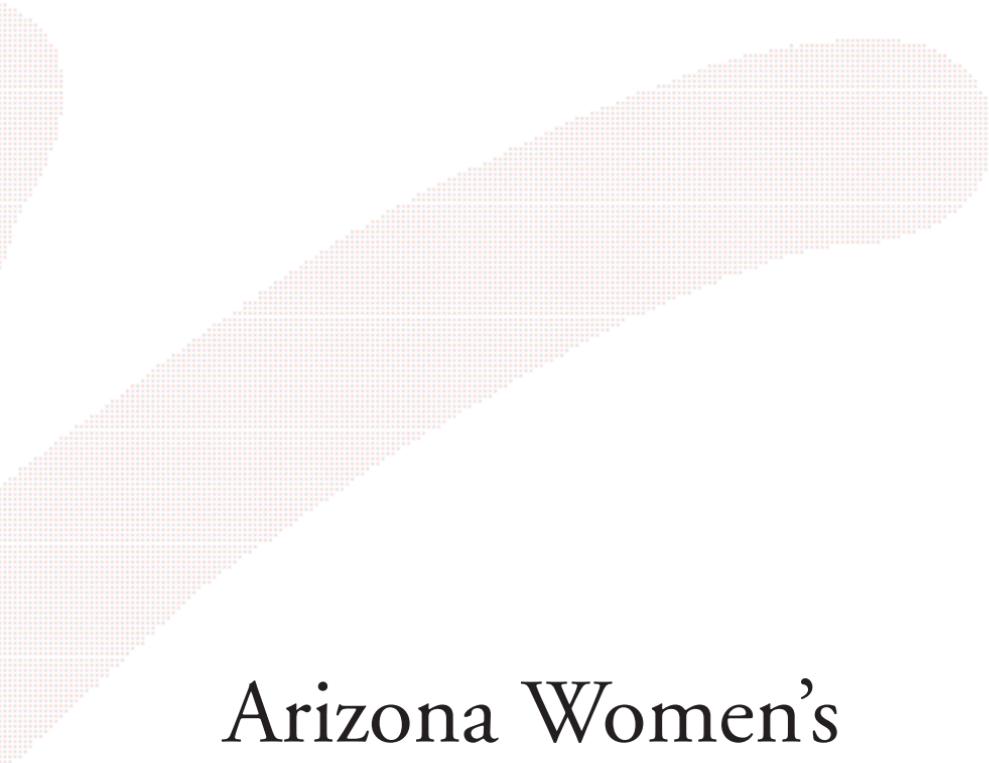




WOMEN *Healthy Women.
Healthy Families.*

Solutions for balanced living



Arizona Women's
Health Survey

Results and Implications

— 2002 —



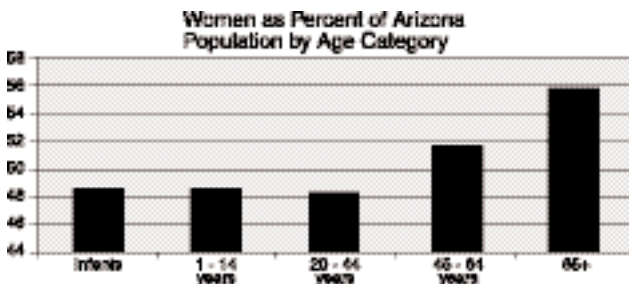
INTRODUCTION

The population of Arizona is becoming increasingly diverse, with a greater percentage of our numbers who describe themselves as Hispanic, African-American, Asian American or Native American than ever before in our states' history. Recent data suggest that annually 1.7 million foreign-born people immigrate to the United States (U.S.), with the majority of these individuals locating to the South and the West (U.S. Census Bureau, 2000). Arizona Department of Public Health data (ADHS, 1999) indicates that non-Hispanic Whites make up 67.4% of Arizona's population, with racial and ethnic minority groups comprising 32.6%. Hispanics represent the largest ethnic group in Arizona, comprising 21.5% of the total population (Mrela, 2000). Women make up slightly more than half the population of Arizona (Hultsman, 2001). The distribution of women among ethnic groups varies somewhat, with non-Hispanic White women comprising 50.01% of the population and greater proportions of Asian Americans (52.57 %) and Native Americans (51.48%) who are women. Smaller proportions of African-American (49.02%) and Hispanic (49.85%) populations are women.

Employment makes up another layer of diversity among Arizona women. More women are employed outside the home than in previous decades. The implications of women's employment include greater access to wages and to health insurance. However, a woman's role as employee adds to her role as wife, mother and caregiver, thus contributing to an already stressful set of circumstances. Further, wages for women continue to lag behind those of men, with women earning about 76 cents for every dollar that men earn despite educational attainment by women approaching that of men.

Overall life expectancy for women in Arizona is 78.58 years, which is slightly greater than the national average and 7 years greater than that for Arizona men. (Mrela 2001) indicates that the distribution of the female population of Arizona by age group is weighted toward those 45 years and older (see Figure 1).

Figure 1



The health status of women has a profound impact, not only on women themselves, but also on their families. The pre-pregnancy health of women is one of the major contributors to healthy childbearing. In addition, women make the majority of health care decisions for families. The increase in overall population and change in diversity of Arizona residents underscored a need to examine women's perceptions of their health in a systematic fashion. Further, the knowledge that proportions of Arizona women tended toward ages over 45 years prompted the Governor's Commission on the Health Status of Women and Families to undertake a population-based survey. This survey characterized the health status of women and identified some of the major issues women face.

Methods

The Arizona Women's Health Survey (AWHS) sampled 1,121 women selected through a random-digit dial telephone survey of those over the age of 18 years. The interviews were collected over a 2-month period in the year 2000. Interviewers contacted residences during weekdays and weekends to obtain the sample. Native American women were intentionally over-sampled using geographically targeted techniques in order to examine

differences between the perceived health status of each ethnic group.

A team made of individuals within the Governors' Community Policy Office (GCPO), Arizona Department of Health Services (ADHS) and experts from Sheila Murphy Associates developed a set of criteria for selecting core questions in the following areas:

- Need-based utilization
- Health care access
- Health information sources
- Health risks and status
- Physical activity and exercise
- Mental health
- Nutrition
- Sociodemographic information

Questions that met the criteria were selected from the previously reviewed population-based survey instruments, including the Arizona Behavioral Risk Factor Survey. Gaps were identified in the core areas and additional questions were generated in order to provide coverage in each major domain being assessed. Test items were administered to a pilot group and necessary language changes were accomplished. Demographic

data were collected in order to support analysis according to characteristics such as age, income and employment status.

RESULTS AND DISCUSSION

The data obtained from the Arizona Women's Health Survey (AWHS) indicate that, while overall trends in women's perceptions of health are positive, concerns exist in the areas of access to care, lifestyle choices and mental health. These findings are described below.

Perceptions of health

Overall, 87.2% of the responding women felt that they were healthier or as healthy as other women their own age, and only 12.8% felt they were less healthy than other women in their age group. There were significant increases in the ratings of health as age, education and income increased. Approximately twice as many women over 55 saw significant health differences, either healthier or not as healthy, as did the group under 35. When compared by ethnic group, Asians, Hispanics and Whites saw themselves as generally quite healthy. The percentage of African-Americans (17.2%) and Native Americans (19.4%) seeing themselves as less healthy than most others exceeded the average by 5 to 7 percent.

Even though 68.7% of the women surveyed considered themselves as often upbeat, optimistic and happy, over one-third of the women (37.1%) reported feeling depressed, anxious or highly stressed during the past 12 months. In general, those most susceptible to depression were those women with minimum education (48.5%) and those with annual incomes under \$25,000 (45.5%). Within the race/ethnic groups, African-American women (45.3%) and Native American women (44.7%) had higher percentages of instances of poorer mental health than the overall response rate for all women. Asian-American women reported the lowest incidence of depression (30.9%). There was a significant difference in the percentage of women between the ages of 35 and 54 (44.6%) and women over 55 (31.7%) reporting feeling depressed, anxious or highly stressed. There was also a significant increase in the frequency of women reporting feeling depressed, anxious or highly stressed among women with annual incomes less than \$10,000 when compared to women in other income groups.

Access to Care

Since, those individuals without health insurance and with no regular health care provider are less

likely to receive preventive services, access to care is an important first step in maintaining health. According to the Arizona Women's Health Survey (AWHS), 84.9% of all respondents reported that they had some form of health care coverage including health insurance plans such as HMOs or Medicare. This figure is similar to the results from a 1999 BRFSS survey conducted by the Arizona Department of Health Services. Differences in access to care among women were noted by factors such as education, age and race. While 35.8% of those with only elementary education do not have such coverage, only 5.9% of those who were graduated from college lack such coverage. Similarly, higher income is also a predictor of coverage; 37.9% of those earning less than \$15,000 reported not having health care coverage. Lack of health care coverage was highest among Native American women (33.2%) and Hispanic women (28.5%). Marital status also impacted on the level of health care coverage. Women who were separated, never married, or members of an unmarried couple more frequently reported having no health coverage.

The majority of respondents (78.9%) did not experience too much difficulty in receiving health care from a health care provider when they needed services.

When asked to rate the level of difficulty on a 4-point Likert-type scale with 1 being extremely difficult and 4 being not at all difficult, the mean rating for all respondents was 3.29. In addition, AWHHS suggests that 80% of Arizona women do have a regular provider of health care. Native American women are least likely to have a regular health care provider and non-Hispanic Whites are most likely to have a regular health care provider.

One discrepancy in access to care corresponds with the ability to obtain services in a manner that is efficient. Recently, investigators from Johns Hopkins have suggested that “the fragmented nature of the U.S. health care system . . . contributes to women’s inability to take advantage of the full range of services they need.” (Strobino, Grason & Minkovitz, 2002). Many women are forced to enter a maze of health care providers in order to obtain care for conditions ranging from pregnancy, gynecological concerns, chronic health and mental health issues. In addition, women’s health needs encompass not only those conditions for which they are at greater risk (e.g. breast, ovarian and cervical cancers), but also those conditions related to the multiple roles that they serve and few health care providers address holistic care.

The AWHHS indicates that women showed age-based preferences for how they obtain health care. When given a choice of options of where they would like to receive their health care, AWHHS respondents indicated that they preferred both a women's health center where they can get basic health care, including gynecological care, in one place (58.7%) or a women's health center that offers health information and referral network (53.1%). There was a significant difference in the percentage of women between ages of 18 and 44 (68.0%) and women age 45 and older (45.1%) who preferred a Woman's Health Center offering holistic health care. Women older than 45 years of age clearly preferred a Woman's Health Center that offered a health information and a referral network.

Lifestyle Choices

Public health successes in sanitation and in the control of many infectious diseases have resulted in greater life spans for U.S. citizens. As a result, the current most frequent causes of death and disability are chronic conditions that have both biologic and environmental components. Since chronic conditions such as cardiovascular disease, diabetes and some cancers may be attributed to smoking, overeating and inadequate

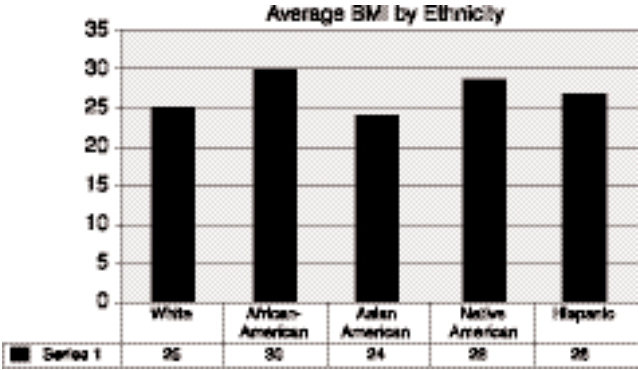
physical activity, lifestyle choices that Arizona citizens make have implications for health. Further, some health concerns that disproportionately affect women, such as osteoporosis, are preventable if appropriate diet and exercise choices are made early in life.

According to the AWHs, 77.0 % of all respondents reported that they had been diagnosed with at least one medical condition during the past five years. As might be expected, as age increased, so did the diagnosis of arthritis, hypertension, thyroid problems, osteoporosis, urinary incontinence, diabetes, heart disease, colon conditions and cancer among women. African-American women had the highest percentage of diagnoses of arthritis (43.0%), hypertension (34.4%), and heart disease (12.9%) among the race/ethnic groups. Both Native American and African-American women had the highest percentages of diabetes (15.8% and 17.2%), both significantly higher than prevalence among White and Hispanic women.

Coronary heart disease is the single leading cause of death for women in the United States. According to the Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion (1998), the average annual mortality rate

among Arizona women from heart disease in 1995 was 86.9 per 100,000 population. Factors contributing to heart disease include high blood pressure, smoking, obesity and physical inactivity. The AWHHS findings showed 20.0% of women with hypertension and 16.4% who smoke. In addition, the respondents' average Body Mass Index (BMI) was 26. This level is classified as overweight and, therefore, places the majority of women at-risk for adverse health effects. All age groups surveyed were at-risk in BMI, with African-American women especially at-risk with a BMI average of 30, a level that classified the group as obese. (See figure 2).

Figure 2



According to a recent analysis of the National Health and Nutrition Examination Survey (NHANES III), as BMI levels rise, average blood pressure and total

cholesterol levels increase and average HDL or good cholesterol levels decrease. Women in the highest obesity category have four times the health risk from either or both of these risk factors.

Further complicating these findings is the lack of information provided to Arizona women regarding their health risks. According to AWHs, only 45% of women in the 45 years and older age ranges indicated they had received specific information about physical fitness or exercise from their health care providers; less than 40% of these women received information regarding nutrition or diet from their health care providers.

Mental Health

The relationship between mental and physical health is well documented. In conditions as diverse as obesity, alcohol and tobacco use, cardiovascular health and fetal development, the effects of psychological stress have been shown to negatively impact physical well being. While the majority of Arizona women surveyed (77.3%) indicated a high level of love and support from family members and friends and 17.8% felt a moderate level of support, the majority of women (51.6%) had experienced a stressful situation within the past 12

months. For the purposes of the survey the following situations were defined as stress producing: severe or chronic illness, for you or a family member; substance abuse by you or a family member; violence in the home, directed toward you or someone else; overcrowded conditions in the home; unemployment; financial problems; marital or relationship problems; or death in the family.

According to AWHs, 31.2% of all respondents felt the need to get help for depression, anxiety or a related concern. Of those women who indicated a need for professional help, 78.1% did seek help from a professional. Among age groups, those women who were in the middle of their careers and personal lives (ages of 35-54) reported a significantly greater need (39.7%) than those women either younger (28.1%) or older (21.4%).

Substance abuse represents part of the cluster of mental health concerns. While overall rates of illicit drug and alcohol use demonstrate downward trends over the past 20 years (RWJF, 2001), use of alcohol and illicit drugs has been linked to family violence, loss of workplace productivity and increased rates of accident and injury. Alcohol remains the most frequently cited drug for those admitted for inpatient or outpatient mental

health treatment (SAMHSA, 2001). According to the AWHHS, 67.6% of those women surveyed reported that during a typical week, they do not consume alcoholic beverages. However, those reporting more frequent alcohol intake were more likely to be between the ages of 18 - 24 or 45 – 54. See Table 1 for specific information.

Table 1 Percent of Respondents Reporting Weekly Alcohol Use (N=1,119)					
Category	None	1-2/wk	3-6/wk	7/wk	>7/wk
Age					
18-24	66.1	18.7	12.6	0.6	2.1
25-34	73.4	15.6	9.9	0.6	0.6
35-44	67.4	22.7	7.8	0.4	1.8
45-54	67.8	13.9	12.3	3.1	2.8
55-64	66.8	12.1	10.6	7.8	2.7
65-74	63.9	22.3	7.4	1.9	4.5
75+	61.2	24.0	9.1	4.6	1.1

Even though women form a relatively small proportion (30%) of those receiving treatment for substance abuse, national data indicate that women may be more vulnerable than men to the effects of alcohol. Women achieve higher concentrations of blood alcohol and demonstrate greater impairment of memory and attention than do

men who consume equivalent amounts of alcohol (NIAAA, 1999). Heavy drinking among women has been linked to heart muscle disease, breast cancer and victimization (e.g. physical and sexual abuse).

HEALTH STATUS ACCORDING TO LIFE STAGE

Women 18-44 years

Reproductive Health

The number of babies born to Arizona residents has steadily increased in the last decade, with approximately 1 baby born for every 60 residents in the year 2000. Arizona Department of Public Health statistics (Mrela, 2000) indicate that the majority of pregnant women (75%) receive early and appropriate prenatal care. However, disparities in peri-natal health care continue, with Hispanics and Native Americans reporting fewer instances of early prenatal care. Additional reproductive health concerns relate to early teen pregnancy with slightly more births occurring to mothers with less than a 9th grade education in 2000 (9.2%) than in the previous year. A significantly greater number of births were to single mothers (39.3%) in 2000, with 8 out of 10 births to mothers 15-19 years old being to single

women (Mrela, 2001). Information provided by AWHs respondents suggests that inadequate emphasis has been placed on nutritional concerns surrounding childbearing. Despite the fact that folic acid intake plays a role in fetal health, only 12.8% of those 18-24 years, 23.1% of those 25-34 years and 18.2% of those 35-44 years reported intake of folic acid supplement.

Reproductive health issues addressed by the AWHs included information about family planning, sexual functioning and medical therapies surrounding menopause. Table 2 summarizes the responses regarding these issues.

Table 2 Percent of AWHs respondents receiving specific information from health care provider (N=1,118)				
All ages	25.6	18.1	9.9	4.8
18-24	3.8	53.0	29.4	12.0
25-34	1.1	43.0	19.5	3.7
35-44	22.9	17.0	11.7	5.5
45-54	56.3	2.6	1.7	4.7
55-64	44.0	1.3	—	2.9
65-74	23.0	0.9	—	0.9
75+	10.1	—	—	—

Substance Abuse

Trends in substance abuse among Arizona residents suggest this health concern is similar to that in other parts of the United States. Estimates of the incidence of illicit drug use ranges from 6 to 8 percent of the population (SAMHSA, 2001), with 8 percent of those in the Western region of the U.S. reporting consuming illicit drugs within the last 30 days. Those younger than 35 years are more likely to report illicit drug use. Deaths related to the use of drugs and alcohol accounted for 2.6 percent of those in Arizona (Mrela, 2000). While the issue of substance abuse may not effect a large proportion of Arizona women, its association with motor vehicle accidents, domestic violence and chronic health conditions make this condition one that affects the quality of life. In addition, little data exists regarding sex-specific risk factors associated with substance abuse or about treatment strategies that are more effective for women.

Women 45 years and older

Chronic Conditions

AWHS respondents who were over the age of 45 years had a significantly higher incidence of chronic

illness during the past 12 months than women of other age groups. Approximately one-half of the African-American women (47.3%) indicated they had a chronic illness; Hispanic women reported the lowest prevalence of chronic illness (15.2%). The chronic conditions most frequently cited by Arizona women were arthritis, high blood pressure, high cholesterol and obesity. Coronary heart disease is the single leading cause of death for women in the United States. Factors contributing to heart disease include high blood pressure, smoking, obesity and inactivity. The AWHHS findings showed 20.0% with hypertension, 16.4% who smoke, 22.4% who said they were overweight or obese, and 54.5% who did not engage in vigorous activities for at least 10 minutes at a time.

According to data from Centers for Disease Control and Prevention, during routine office visits, women were counseled less often than men about exercise, nutrition and weight control (CDC, 1998). Many women, especially those middle-aged and older, are unaware that coronary heart disease is the leading cause of death for their age group; this misjudgment may contribute to their risk (Wilcox & Stefanick, 1999). According to AWHHS, approximately 45% of women in the middle-aged and older range indicated they had received specific information about physical fitness or

exercise; less than 40% of these women received information regarding nutrition or diet from their health care provider.

RECOMMENDATIONS

While the AWHHS provides a snapshot of women's health information, this information only becomes useful to individuals and communities when it is paired with action. Actions associated with the findings of this survey have the potential to influence individuals and communities and have relevance to education and policy. Criteria indicating appropriate action from these data include the following:

- Applicable to women of every life-stage (e.g. adolescents, women of childbearing age, mid-life women and post-menopausal women);
- Primary prevention focused;
- Consistent with national priorities;
- Supported by scientific evidence;
- Change in status is measurable.

From the AWHHS the areas of concern most consistent with these criteria include number of Arizona women who are obese/overweight and the overall levels

of fitness of Arizona women. A variety of sources indicate that improvements in fitness influence both physical and psychological well being. Obesity is a serious risk factor for Arizona women in terms of cardiovascular health and one way to improve cardiovascular health is through appropriate physical activity. In addition, physical activity is a vital treatment and prevention strategy for osteoporosis, a condition in which women are more likely to be affected than men. Scientific data points to exercise as having some effect in estrogen-dependent cancers, such that the more a woman exercises, the less likely she is to develop breast or uterine cancers. A recent review of scientific literature demonstrates that physical activity can also play a role in treatment for depression (Lawlor & Hopker, 2001). Clearly, opportunities exist to address these health concerns.

After review of survey results, members the Commission on the Health Status of Women and Families developed a consensus regarding priority concerns and suggested strategies to address those concerns. Since techniques for dealing with the priority health issues overlapped, the Commission recommended that an emphasis on physical activity and fitness be the primary focus of ongoing efforts. The Commission has identified specific recommendations that are outlined on the following pages.

I. Support community-wide campaigns to promote physical activity for women.

Physical inactivity and dietary patterns are second only to tobacco use as a leading cause of preventable death in United States. Research shows that large-scale, high-intensity, community-wide campaigns are effective in increasing measures of physical activity. The Commission recommends campaigns with multiple components, but a single message such as the Arizona Department of Health Services, project titled: “Feeling Great, It Happens When You Move”. Suggested activities include:

- Organize community-wide exercise “Nights Out”.
- Initiate regular walks with neighbors.
- Hold block parties that incorporate physical activity.
- Develop and distribute information about simple ways to increase activity as a regular part of daily life.
- Conduct media campaigns including television, radio, newspaper columns and inserts, and trailers in movie theatres raising awareness of the need for increased physical activity.

- Hold support and self-help group meetings.
- Adopt a pro-fitness approach to activity counseling.
- Create safe walking trails in parks and neighborhoods.
- Encourage opportunities for physical activity in the workplace.
- Provide screening and education for target groups including those women with diabetes; women who are obese; single, working mothers; and post-menopausal women.

II. Support school-based efforts aimed at the developing a physically active lifestyle for girls.

Regular physical activity is associated with enhanced health and reduced risk for all causes of mortality. Health habits established in childhood have the best chance of remaining a part of a woman's life. With the decline in physical education and recess as routine parts of each school day, it is not surprising that The Arizona Women's Health Survey found that only 45.5% of Arizona women reported engaging in vigorous activities that cause large increases in breathing or heart rate, for at least 10 minutes at a time. The Commission recommends strong support for school-based efforts that

encourage the development of a physically active lifestyle for girls. Specifically:

- Emphasize activities for youth that can be practiced throughout a lifetime.
- Position physical activity as a regular part of school curricula.
- Provide age-appropriate health education.
- Modify school curricula and policies to increase the amount of time spent in vigorous activity.
- Increase the amount of time spent in physical education class.
- Increase the amount of time students are active during the school day.

III. Incorporate behavioral and social approaches to increasing physical activity for women.

Specific behavioral approaches have been effective in improving physical activity for women as measured by minutes spent in activity. The Commission recommends support for behavioral skills development to support physical activity for women that:

- Focus on attainable goals that are family friendly.
- Include goal setting and self-monitoring.
- Incorporate social support and culturally sensitive strategies.
- Provide reinforcement through self-reward.
- Include structured problem-solving and relapse prevention.

POPULATION-BASED STRATEGIES

Prominent strategies associated with the goal of improved fitness for Arizona women include both short-term and long-term approaches. Short term strategies include initiating dialogues with groups and organizations currently involved in population-based methods aimed at increasing physical activity. These groups include:

- Governmentally-funded agencies
- Business owners and employers
- Groups within the fitness industry
- Community activists from charities
- Neighborhood associations
- Representatives of faith-based organizations

The objective of such discussion would be to share successes and to develop consistent communication regarding simple, safe, low cost alternatives to increase women's physical activity and fitness. Of particular interest would be identifying approaches that address cultural concerns and that could be differentially applied based on age or other demographic characteristics.

Long-term strategies include:

- 1) Develop and identify funding for media campaign(s) to educate, increase awareness and stimulate action surrounding the benefits of increased physical activity and fitness.
- 2) Develop proposals and pursue funding for research studies to illuminate effective motivational strategies to enhance women's physical activity.
- 3) Partner with interested organizations to target populations particularly vulnerable to low levels of fitness.
- 4) Formulate a course of action to influence public policy aimed at improving the environment supporting physical activity and fitness. Such policy issues include actions by educational systems, employers and communities.

Respondents to the AWHIS indicated that barri-

ers to physical activity include inadequate time (30.2%), physical limitations (25.6%) and no place to exercise safely (6.1%). For many citizens, the workplace increasingly represents the community to which they belong. Workplace strategies that support physical activity as a routine part of the workday as well as exploration of more flexible elder care and child care options and work flexibility for women are all appropriate responses to the need for improved fitness. In addition, increased community emphasis on safe public spaces could have a positive influence on exercise frequency for Arizona women.

Many of the indicators of better health for Arizona women seem to be associated with higher levels of education. Directing resources to techniques that encourage students to stay in school and to pursue higher education has benefit for the economic and health status of Arizona women.

An issue not specifically addressed by the AWHHS, but which holds relevance to women's health is that of routine inclusion of sex/gender as part of health, health care and injury/disability data collection systems. While some measures of morbidity and mortality (e.g. death, cause of death) are collected and reported by

sex/gender, improvements in reporting by sex/gender in such elements as hospital admission, mental health and substance abuse treatment could be seen with changes in existing data collection and analysis systems.

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JANET NAPOLITANO

GOVERNOR

STATE OF ARIZONA

**GOVERNOR'S OFFICE FOR CHILDREN,
YOUTH AND FAMILIES**

WITH SUPPORT FROM

**THE ARIZONA DEPARTMENT
OF HEALTH SERVICES
OFFICE OF WOMEN'S
AND CHILDREN'S HEALTH**

AND

**THE TITLE V MATERNAL AND
CHILD HEALTH GRANT**

**GOVERNOR'S COMMISSION ON
HEALTH STATUS OF WOMEN
AND FAMILIES IN ARIZONA**

Mission: To advance the physical and mental health of Arizona women and families by assessing health status and its impact on the social and economic good of the State and its citizens, and by identifying strategies and developing policies and legislative recommendations to improve health.



Guiding Principles:

- Focus on:
 - Primary and secondary prevention.
 - Improved access to mental and physical healthcare.
 - Behavior and lifestyle as opportunities for improved health.
 - Reducing the number of uninsured women
 - Being economically driven.
 - Increasing personal knowledge/education.
- Activities designed to meet the needs of diverse populations in a variety of circumstances within the State.
- Part of a long-term effort.
- Commitment to the awareness-education-accountability continuum of personal responsibility.



Commission Goals:

- **Research** – To define the current health status of women in Arizona and its impact on the State.
- **Policy** – To influence policy in Arizona to improve women's health.
- **Awareness** – To increase awareness throughout the State about ways each woman can improve her health.
- **Linkage** – To coordinate efforts among Arizona's community organizations, businesses and state agencies to improve women's health.

January, 2001

